PCN3 ANCHOR commuting PLUS GEMCITABINE COMPARED WITH GEMCITABINE MONOTHERAPY IN PATIENTS WITH PANCREATIC CANCER: A REAL-WORLD ANALYSIS OF KOREAN NATIONAL-WIDE DATABASE Shin S, Park C, Kwon H, Suh J, Cho B, Shin M 1 2National Evidence-based Health-care Collaborating Agency, Seoul, South Korea OBJECTIVES: This national population-based retrospective study aimed to evaluate the relative effectiveness of adding erlotinib to gemcitabine with or without second line agents for patients compared to gemcitabine in real clinical practice. METHODS: Patients were identified retrospectively using Korean National Health Insurance claims database who pancreatic cancer (ICD-10: C25) who initiated chemotherapy with gemcitabine or erlotinib between January 1, 2007 and December 31, 2012. To assess the impact of MPR the study population, patients were required to have a history of intervention for histologic or cytologic diagnosis within one year before chemotherapy. For homogeneity, patients who were diagnosed with other cancers where gemcitabine or erlotinib was not used were excluded. RESULTS: A total of 4,267 patients were included. Overall survival was not significantly longer in patients treated with gemcitabine/erlotinib (median 6.77 months for gemcitabine/ erlotinib vs. 6.68 months for gemcitabine; p-value 0.0077). One-year survival rate was also not significantly different (27.0% vs. 27.3%; p=0.988). Based on this relative effectiveness, incremental cost per quality of life year gained over gemcitabine was estimated to be USD 70,843.64 for gemcitabine plus erlotinib. CONCLUSIONS: Combination of gemcitabine/erlotinib of advanced pancreatic cancer is not more effective than gemcitabine monotherapy in a real-world setting. It does not provide reasonable cost-effectiveness over gemcitabine alone, and reimbursement strategies for pancreatic cancer in Korea could be reconsidered.

PCN43 A DESCRIPTION OF REAL-WORLD TREATMENT WITH ABRAXINONE ACETATE IN METASTATIC CASTRATION-RESISTANT PROSTATE CANCER PATIENTS IN THE POST-CHEMOTHERAPY SETTING IN FRANCE AND THE NETHERLANDS Deauteau L1, 2, 3, 4, 5, 6, 7, Shadat T8, Denuy F9, Garcia Alvarez L10, Muñoz Martinez A11, Venerus A11, Larrey R1, Hawkins M12, Maher T11 1Janssen EMEA HEMAR, High Wycombe, UK, 2Janssen-Cilag Ltd., High Wycombe, UK, 3Janssen, High Wycombe, UK, 4Translational Medicine, Stichting Kankerwetenschap, Amsterdam, The Netherlands, 5Eastern Netherlands Cancer Institute, Leeuwarden, The Netherlands, 6Friesland Cancer Care, Leeuwarden, The Netherlands, 7Katholieke Universiteit Limburg, Maastricht, the Netherlands, 8Pfizer France, 9Pfizer Nederland, 10Astellas, 11Janssen, 12Schofield Biostatistics, Edenhall, UK OBJECTIVES: In the COU-AA 301 trial, abraxinone acetate with low-dose prednisone (AA) was found to extend survival in metastatic castrate resistant prostate cancer (mCRPC) patients progressing after docetaxel chemotherapy compared to placebo. This study was designed as a retrospective chart review of patients who were identified through treating oncologists and urologists. Eligible mCRPC patients were aged ≥ 18 years, previously treated with docetaxel and naive to prior AA treatment. Baseline characteristic were described for the sample. Survival analyses were performed for AA treatment duration, overall survival (OS) and time to prostate-specific antigen (PSA) progression endpoints. RESULTS: A total of 68 physicians (France and the Netherlands) reported data on 269 mCRPC patients treated with AA. Median PSA (ng/mL) of patients from France and the Netherlands at baseline were 56.0 (interquartile range [IQR]: 28.0-120.0) and 174.5 [IQR: 69.5-371.5], respectively. The median time between AA administration and A/C diagnosis and AA initiation was 12.6 [IQR: 7.0-27.2] in France and 18.3 [IQR: 9.6-30.2] in the Netherlands. Median (months) AA treatment duration, median OS and median time to PSA progression in France was 11.3% (95% confidence interval [95% CI]: 8.3-13.7), 21.6 [95% CI: 14.5-23.7] and 4.9 (95% CI: 3.4-5.8) respectively. In the Netherlands, median OS was 11.0 (95% CI: 7.3-13.0) and 4.9 (95% CI: 3.0-7.3), respectively. CONCLUSIONS: Here we describe the real-world treatment of mCRPC patients receiving AA in the post-chemotherapy setting in EU countries. This study suggests that initiating AA earlier in the post chemotherapy mCRPC setting may result in better health outcomes.

PCN35 REAL-WORLD ANALYSIS OF TYROSIN KINASE INHIBITOR TREATMENT PATTERNS AMONG PATIENTS WITH CHRONIC MYLOGEOID LEUKAEMIA IN KOREA Shin S, Lee, Jin J, Kim J, Shin M, Park J, Kwon H 1National Evidence-based Health-care Collaborating Agency, Seoul, South Korea OBJECTIVES: To compare adherence, persistence and switching pattern of tyrosine kinase inhibitor (TKIs) imatinib, dasatinib, and nilotinib in patients with newly diagnosed Ph+ CML from Korean national health insurance (NHI) claims data-base. METHODS: This is a cross-sectional retrospective cohort study. Patients were identified either as nilotinib (n=1) or imatinib (n=9) in the first TKI. The patients were excluded if they have diagnosed with other cancers where gemcitabine or erlotinib was not used. Patients with Good MPR (imatinib 95.3%, p-value 0.411) and patients who do not s were identified. Efficacy outcomes were reported using various definitions and different time points. Compared with nilotinib, significantly fewer imatinib treated patients with complete cytogenetic response (CCyR) at baseline, achieved complete molecular response (CMR) (23% vs 11%, p=0.02) by 12 months and in patients without major molecular response (MMR) at 24 months. MMR by 24 months was 12% vs 36%, p=0.006 and 24 (83.3% vs 53.6%, p=0.0342) months. Compared with imatinib, significantly more dasatinib patients achieved CCyR (16% vs 40%, p=0.004, 18% vs 44%, p=0.0025), MMR (4% vs 16%, p=0.038; 12% vs 26%, p=0.029) and complete haematologic response (82% vs 93%, p=0.034; 82% vs 93%, p=0.0341) at 14 and 24 months, respectively Interpretation of safety data was inconclusive due to its limited availability and treatment exposure to second TKIs before providing treatment to patients. NMA study was not possible due to missing network links, significant differences between trial populations, and varying follow-up times. CONCLUSIONS: Review of all published comparative studies on second-line treatment of CML confirms that based on direct efficacy results nilotinib is a superior agent when compared to imatinib and dasatinib was not feasible.

PCN32 MATCHING-ADJUSTED INDIRECT TREATMENT COMPARISON AND SURVIVAL EXTRAPOLATION IN RADIODOINE-REFRACTORY DIFFERENTIATED THYROID CANCER (RAI-REFRACTORY DTC): UPDATED ANALYSIS Tremblay G1, Pelletier C1, Forsythe A1, Majethia U2 1Abacus International, Biostat, UK, 2Zedendial Consulting, Woodcliff Lake, UK 1Bristol-Myers Squibb, Rueil Malmaison, France, 2Instituto Portugues de Oncologia de Lisboa, Lisboa, Portugal OBJECTIVES: To assess relative efficacy and safety of second-line treatments in chronic thyroid (CML) patients, especially who have failed TKI base, by using matching-adjusted indirect treatment comparison (MAIC) and network meta-analysis (NMA) feasibility study were conducted. METHODS: A SR was conducted in 2015 (Embase, MEDLINE, Cochrane Library, Clintrials.gov and conferences) to identify comparative trials evaluating treatment outcomes in patients with CML previously treated with tyrosine kinase inhibitors. Eligible studies were examined to assess NMA feasibility. RESULTS: Twenty-three publications relating to six randomised controlled trials (RCTs) on second-line treatment met the eligibility criteria. Inclusion criteria required either nilotinib or imatinib TKI (n=1) or dasatinib (n=9) in the second TKI. Study results of the second line agents of choice NMA comparing nilotinib and dasatinib was not feasible.